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## Converting a Teaching Hospital Medical Clinic to a Group Practice: Patients Vote with Their Feet

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## Synopsis .....

*Traditional general medical clinics (GMCs) have been criticized as providing less than optimal primary care while losing money for the sponsoring teaching hospital. In addition, the GMC has become less attractive as a site for training house staff.*

*In response, a number of teaching hospitals have sponsored the development of a primary care group practice as a more efficient alternative to the GMC. Under the new model, certain measures of patient*

*care frequently improve, house staff receive better training, and the hospital may be able to trim financial losses.*

*While the literature contains numerous descriptions of such conversions, very little information is available about the compliance of patients who are transferred to the new model with relatively little preparation or choice. Institutions that convert their GMCs may do so to attract new clientele. But they have a responsibility to their long-time patients and certainly should address the question of whom they expect to transfer successfully and what the dropout rate will be.*

*New York City's Mount Sinai Hospital completed conversion of its GMC to a primary care group practice in 1983. A sampling of patients taken before the conversion, then followed up 6 months later, revealed that 82 percent of the former GMC patients were successfully referred to the new model. Patients given specific appointments rather than instructions to call for their own appointment had a better "show" rate. Noncompliers were more likely to be female, Medicaid-covered, 46–65 years old, and living outside the hospital's immediate service area. Our data suggest that when hospitals close a GMC and transfer patients to a hospital-sponsored alternative, they can expect to refer most patients successfully.*

EVIDENCE THAT TEACHING HOSPITALS are dissatisfied with their traditional general medical clinics (GMCs) abounds. The literature has adequately documented the reasons for this dissatisfaction (1,2), the alternatives that address the problem

(3–5), and some of the results of conversion to various new models for provision of care (6,7).

Some converted GMCs have as a goal attracting a new clientele. Others expect to shift their current patients to a new model. Still others have not con-

verted their GMCs to new models in part because of their concern for successfully effecting the transfer of these patients. Current literature provides little information that would guide an institution as it addresses the referral of patients from a GMC to a group practice. In planning a conversion, several important issues arise:

- When patients are referred from a GMC to its replacement, how much effort should be made to educate them about the replacement?
- What is the likely rate of compliance with the referral?
- Of the current demographic and payer mix of patients, which groups of patients are most likely to be lost in the referral process?
- Where (if anywhere) do former GMC patients who do not go to the new facility seek alternative care?
- What proportion of the GMC patients also receive care elsewhere, and is the move to a group practice associated with a decline in nonurgent use of the emergency department?

In this paper, we provide information about the experience of one hospital's conversion of its GMC to a primary care group practice. Further research needed to answer some of the questions just posed is continuing, and the results will be provided at a later date.

## Background

Over the last few years there has been growing recognition that, for organizational, fiscal, educational, and quality-of-care reasons, GMCs at teaching hospitals are no longer a tolerable mechanism for delivering primary care.

Organizationally, the GMC developed as a diagnostic clinic as well as an attempt to alleviate the growing fragmentation of outpatient care at teaching hospitals into specialized clinics—a fragmentation that paralleled the increasing specialization of health care technology, therapy, and training. Thus, the historical intent was that GMC staff would “manage” the patients’ care, directly providing primary care and referring patients to other, more specialized clinics for—and only for—episodes or conditions not usually treated by a generalist.

In actual practice, however, a GMC patient may be “followed” by a number of clinics for several conditions that are organizationally separate but clinically overlapping. The GMC is left to manage the residual episodes that interest no other clinic. No clinic can, therefore, be said to be managing the

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patient, who is more likely to seek primary care on a walk-in basis at the emergency room than by appointment at the GMC (8).

Fiscally, the GMC has traditionally been seen as a money-losing service (9,10)—indeed, as charity care which the hospital has felt an ethical obligation to provide to poor residents of the inner city who could not afford primary care. Even with Medicaid, it is clear that reimbursement to hospitals for GMC visits is frequently insufficient to cover costs. For example, during 1978, before conversion of the GMC at Mount Sinai Hospital in New York City to a primary care group practice, costs of operating the GMC averaged \$82.24 per patient visit. Net revenue during the same period averaged only \$41.49 per visit. Medicaid did not cover the costs for its insured patients, but a more significant loss was attributable to the 30 percent of patient visits that were not covered by third-party insurance. These “self-pay” patients paid an average of only \$13 per visit, resulting in a loss of almost \$70 per visit for 6,000 self-pay visits during 1978 alone.

Educationally, the GMC has been the major outpatient training arena for medical residents who, under supervision from faculty and attending physicians, learned to be health care providers. More recently, however, the GMC has all but lost its attractiveness as a teaching site (11). Faculty and attending physicians have lost motivation and often, as a result, do not provide enthusiastic supervision of house staff. The attending physicians perceive GMC patients as clinically uninteresting, low on compliance with regimens, and likely to miss appointments. Residents see outpatient care as less prestigious than inpatient care, and they view the GMC as particularly unrewarding in comparison with the more specialized clinics, which have patients (often on referral from the GMC) with more interesting and educational conditions.

All of these factors have led to profound deficiencies in the quality of care received by GMC pa-

*'But by far the most popular alternative to the traditional general medical clinic is the hospital-sponsored group practice. . . . Under this approach, the GMC is closed, and patients are referred to a group practice of primary care providers who coordinate and manage the patients' care.'*

tients. A GMC patient may be receiving care from a number of specialized clinics (hypertension, diabetes, and so on) in addition to the GMC and also may receive care from the emergency department at times when the GMC is closed. The patient's medical record is frequently unavailable, or remains unread, at the multiple sites of care. Care is, therefore, fragmented and uncoordinated and may result in incompatible or interacting treatments received from a number of providers, each unaware of the other.

**Alternatives to the GMC.** In light of these factors, most teaching hospitals have considered modification of the traditional GMC structure, and several models have been attempted (12). Agustin (3,13) described one model in which all outpatient clinics were replaced by a neighborhood family care center. Other hospitals have established satellite primary care programs beyond the hospital campus (14,15). Still other modifications have included the expanded use of nurse practitioners in ambulatory care (16), conversion to a private office practice (7), and hospital sponsorship of a prepaid group practice (HMO) (17).

But by far the most popular alternative to the traditional GMC is the hospital-sponsored group practice. In particular, the Robert Wood Johnson Foundation in its Community Hospital Program, which began in 1976, helped 54 community institutions reorganize their approach to primary care (18). Under this approach, the GMC is closed, and patients are referred to a group practice of primary care providers who coordinate and manage the patients' care. Patients may be referred elsewhere for specialized care but remain under the management of the primary care provider.

The ability of hospital-sponsored primary care group practices to handle GMC patient loads efficiently, use nonphysician providers effectively, lower the number of broken appointments, and relieve specialty clinics of primary care case loads has been well documented (10). Little information is

available, however, on the initial referral of patients to the new group practice from the traditional GMC. Much of the literature is uncritical and specifically neglects the crucial period when the GMC is closing and the group practice is opening. Although the practice aims at attracting new clientele (that is, new to the hospital) in the initial year, it is dependent on the GMC patient population. Indeed, since the attractiveness of the group practice alternative is the major reason for recommendations that teaching hospitals close their GMCs, hospitals have an obligation, from the standpoints of both planning and ethics, to answer the following questions before doing so:

- What proportion of GMC patients will comply with a referral to a group practice if the GMC is closed?
- What kind of GMC patient is at greatest risk of not complying and therefore in greatest need of special educational efforts?
- Will those GMC patients complying with the group practice referral show up at the group practice for their first scheduled appointment, or will they delay?
- Will those GMC patients not complying with the referral secure care elsewhere, outside the hospital?

Despite the obvious importance of this information for a hospital contemplating closing its GMC—and despite the legal, clinical, fiscal, and managerial hazards of not knowing—none of the published articles provide any guidance in this respect. In view of this, Mount Sinai Medical Center has addressed these issues from its own experience, in 1983, of closing its GMC. This article deals with the first three questions; a later one will deal with the fourth.

### **The Mount Sinai Experience**

Many of the problems associated with the traditional GMC were faced by New York City's Mount Sinai Medical Center, which has a 1,212-bed teaching hospital at which there are 400,000 patient days of hospitalization, 35,000 discharges, and 300,000 outpatient visits annually. Although Mount Sinai's private patients are drawn from affluent communities within and outside the city, the hospital's outpatient clinics have traditionally cared for poorer residents of the communities of East Harlem and South Bronx.

During the late 1970s, Mount Sinai operated a very traditional GMC to which approximately 6,000

patients made 20,000 visits a year. The patients were predominantly community residents with Medicare, Medicaid, or no insurance. They were either self-referred or referred by the emergency room or another specialty clinic.

Medical services were delivered by 80–90 house officers who rotated through the GMC so that most were present one session per week for less than half of each year. Voluntary attending physicians also saw patients, although there were some attendance problems. The full-time clinic chief frequently spent his time writing medication refill orders rather than supervising house staff.

To deal with many of the GMC problems already identified, the chairman of the Department of Medicine in 1979 formed a committee to plan a group practice that would at once improve the quality of services to patients, improve the quality of house officers' educational experience in ambulatory care, and attract a full-time faculty devoted to general internal medicine and primary care. Planning for the conversion coincided with a request for proposal from the Robert Wood Johnson Foundation, which eventually provided considerable financial support and technical assistance for the project.

Internal Medicine Associates, the name adopted by the faculty group, was formed within the Mount Sinai Hospital legal framework in July 1980. The IMA faculty began by seeing patients in the GMC that fall. The patients were subsequently referred to IMA for followup.

To meet the objective of converting the traditionally organized GMC to a group practice model, a phasing-in process was planned. Between 1980 and July 1, 1983, new space in a building two blocks away was renovated, new staff were hired and trained, physicians were recruited, delivery of services was reorganized, and all GMC patients and medical house staff were incorporated in the IMA model.

The phase-in process involved periodically closing several GMC sessions while opening an equivalent number of patient appointment slots at IMA. This was done several times during the 3-year transition period. Each time sessions in the GMC were reduced, staff and space at IMA were increased to accommodate the expected increase in patient visits.

Patient education about the new group practice consisted of a one-page flyer and an appointment reminder letter from IMA. Until the GMC finally closed in June 1983, the patients were offered the choice of either site. The length of the queue operated to regulate the flow of patients to the new site.

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**IMA today.** IMA is a single-specialty group practice in internal medicine. Six full-time faculty amount to 4.2 FTEs (full-time equivalents) actually in the group. Providers also include house staff, nurse practitioners, and social workers. Administrative functions of ambulatory care, such as registration of patients, cashiering, medical records, and other administrative support activities are handled at IMA, but also specimens are collected onsite and sent to hospital laboratories. Radiology and other special tests are provided elsewhere in the hospital.

The group operates weekdays from 8:30 a.m. to 5:30 p.m. A faculty member is on call during all other hours. The group now has 6,000 registered patients who make about 20,000 visits per year. Social workers record about 3,000 encounters annually.

A review of new patients who came into the practice last year showed that the mix of patients with respect to payer category has changed little from that served by the old GMC.

### **Patient Compliance Study**

As indicated previously, the Mount Sinai GMC closed at the end of June 1983, and all patients were given followup appointments at IMA or told to contact IMA for future care. Patients were given a one-page flyer on IMA and told that the GMC was closing. The GMC met for the last time on June 28.

A clerk was assigned to collect basic data on every patient seen in the GMC during the last four days of its operation. In addition to demographics, the specific date of the followup appointment scheduled for IMA was noted, if, in fact, a specific appointment had been given. Data were obtained from the GMC appointment books and clerical staff to ensure that every patient seen during the 4 days was recorded.

Six months later, patients' charts at IMA were reviewed to determine how many of the GMC pa-

Table 1. Compliance with referral to a hospital-sponsored primary care group practice by patients seen during the last 4 days of operation of Mount Sinai Medical Center's general medical clinic<sup>1</sup>

Compliance	Number	Percent
Patients given specific appointment . . . .	88	<sup>2</sup> 99
Complied day of appointment . . . . .	40	45
Complied late:		
1-7 days . . . . .	6	7
1-4 weeks . . . . .	8	9
1-3 months . . . . .	11	12
4-6 months . . . . .	8	9
Complied before appointment . . . . .	8	9
Did not comply . . . . .	7	8
Patients told to call IMA for appointment during a specific month . . . . .	81	<sup>2</sup> 101
Complied during the specified month . . . . .	24	30
Complied late:		
1-3 months . . . . .	21	26
4-6 months . . . . .	3	4
Complied before appointment . . . . .	9	11
Did not comply . . . . .	24	30

<sup>1</sup> 195 patients were seen during the 4 days; 169 were referred.

<sup>2</sup> Percentages do not add to 100 because of rounding.

tients recorded for the study had complied with the IMA referral. The hospital outpatient charts were reviewed to document emergency department and other clinic use by the referred GMC patients, whether or not they came to IMA.

Further study was required to trace patients not found in IMA. Noncomplying patients are being followed up by phone or in person to determine whether and where they are receiving health care.

**Results.** During the last 4 days of GMC operation, information on 195 patients was collected. As shown in table 1, of those 195, 88 patients were given a specific appointment, and 81 patients were told to contact IMA during a particular month to request an appointment. (The remaining 26 patients who were not given an appointment were told that if, in the future, they needed medical care, they should phone IMA.)

Of the 88 patients given a specific appointment, only 8 percent had not made a visit to IMA within 6 months, and nearly one-half (45 percent) had shown up on the actual assigned day (table 1). Seven percent were up to a week late in keeping their appointments, and 9 percent were 1-4 weeks late.

Of the 81 patients told to contact the IMA for an appointment during a particular month, 30 percent did so, while 30 percent had not done so 6 months later.

Of the 169 patients who were either given a specific appointment or told to make one during a

particular month, 81 (48 percent) were "early compliers" (seen on or before the assigned day or month), 57 (34 percent) were "late compliers" (came to IMA after date or month due), and 31 (18 percent) were "no-shows" (had not visited IMA 6 months after referral).

Table 2 compares the characteristics of late compliers, early compliers, and no-shows. The no-shows were more likely to be female, to be covered by Medicaid, to be younger, and to live outside the immediate hospital area than the other two groups.

Table 3 presents these data differently to show the percentage of patients who complied with referral, by selected characteristics. Ninety-six percent of males and 91 percent of females were compliant. Older patients were more likely to be compliant than younger ones, as were patients living within the immediate area of the hospital. Medicaid-covered patients had a higher no-show rate than Medicare-covered patients.

## Summary and Conclusions

Many teaching hospitals are dissatisfied with their general medical clinics because of fiscal, training, and quality-of-care issues and are considering replacing them with some alternative primary care arrangement, such as a hospital-sponsored group practice. In making the decision about whether to close a GMC and in planning for its replacement, hospital planners should evaluate the need to transfer some or all of the existing GMC patients to the new model. Some data on which patients they can expect to transfer successfully to the new model will be helpful.

An opportunity to examine this problem arose when the Mount Sinai Medical Center in New York City elected to replace its GMC with a hospital-sponsored primary care group practice. Demographic and referral data were recorded on all 195 patients seen during the last four sessions of the GMC in June 1983. Our evaluation of that data and of followup data obtained 6 months later addresses the question of compliance with the initial referral as a measure of successful transfer of patients to the new model.

Of the 195 patients, 88 were given followup appointments at the group practice, and 45 percent of these patients kept their appointments on the assigned days. Only 8 percent had not visited IMA by the end of 6 months.

An additional 81 GMC patients were told to call IMA and make their own appointments during particular months. Thirty percent did so, and an addi-

Table 2. Percentage of patients in three compliance groups, by selected characteristics

Characteristic	"No shows" <sup>1</sup> (N = 31)	Early compliers <sup>2</sup> (N = 81)	Late compliers <sup>3</sup> (N = 57)
Sex:			
Male .....	11	19	16
Female .....	89	81	84
Player status:			
Medicaid .....	57	30	21
Medicare .....	14	33	30
Medicare and Medicaid .....	0	20	30
Other (insured and uninsured) .....	29	17	19
Age (years):			
19-45 .....	25	8	7
46-65 .....	38	38	44
66-75 .....	12	31	21
76 and above .....	25	23	28
Residence:			
Immediate area .....	31	49	39
Rest of Manhattan .....	31	25	25
Bronx .....	23	21	32
Brooklyn .....	15	0	2
Other .....	0	5	2

<sup>1</sup> Had not visited Internal Medicine Associates, Mount Sinai-sponsored primary care group practice, 6 months after referred by closing Mount Sinai general medical clinic.

<sup>2</sup> Kept appointments at Internal Medicine Associates before or at the expected time (month or day).

<sup>3</sup> Came to Internal Medicine Associates after the expected time.

tional 30 percent complied within 1-6 months. Thirty percent had not complied after 6 months.

Thus, with either an appointment or a suggestion that the patient make his or her own appointment, all but 18 percent of 169 patients of the GMC were successfully referred to its replacement, even though patient education was limited to an appointment reminder letter and a one-page flyer and even though most appointments took place about 3 months later, at a building separate from the GMC, in a large medical center complex. If all patients had been given a specific appointment, it is estimated that the dropout rate would have been reduced to less than 10 percent.

Noncompliers were more likely to be female Medicaid recipients, 19-45 years of age, and living outside the hospital's immediate area. Where the noncompliers went for care and how long the compliant patients will stay with IMA is currently being studied. Meanwhile, however, Mount Sinai's experience shows that, with minimal educational efforts by hospital staff, 82 percent of the transferred patients complied with referral when the hospital closed its traditional GMC in favor of a hospital-based alternative.

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Table 3. Percentage of patients complying with referral to Internal Medicine Associates, by selected characteristics<sup>1</sup>

Characteristic	Percent complying
Sex:	
Male .....	96
Female .....	91
Payer status:	
Medicaid .....	89
Medicare .....	98
Medicare and Medicaid .....	100
Other (insured and uninsured) .....	91
Age (years):	
19-45 .....	82
46-65 .....	94
66-75 .....	97
76 and above .....	94
Residence:	
Immediate area .....	93
Rest of Manhattan .....	89
Bronx .....	91
Brooklyn .....	33
Other .....	3

<sup>1</sup> 169 patients were referred; 138 complied with referral.

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## The Attitudes of Consumers toward Direct Advertising of Prescription Drugs

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### Synopsis .....

*Attitudes about prescription drug advertising directed to consumers were assessed in 1,509 persons who had viewed prototypical advertisements for fictitious prescription drug products.*

*Although many subjects were generally favorable toward the concept of drug advertising directed to consumers, strong reservations were also expressed, especially about television advertising.*

*Prescription drug advertising did not appear to undermine the physician's authority, since respondents viewed the physician as the primary drug decision-maker. However, the physician was not perceived as the sole source of prescription drug information.*

*Television advertising appeared to promote greater information-seeking about particular drugs; however, magazine ads were more fully accepted by subjects. Furthermore, magazine ads led to enhanced views of the patient's authority in drug decision-making. The greater information conveyed in magazine ads may have given subjects more confidence in their own ability to evaluate the drug and the ad.*

*Ads that integrated risk information into the body of the advertisement were more positively viewed than ads that gave special emphasis to the risk information. The results suggest that consumer attitudes about prescription drug advertising are not firmly held and are capable of being influenced by the types of ads people view. Regulation of such ads may need to be flexed to adapt to the way different media are used and processed by consumers.*

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**T**RADITIONALLY, THE PROMOTION OF PRESCRIPTION drugs has been limited to physicians and other health professionals who dispense or administer

medicines. Several pharmaceutical companies, however, have recently expressed an interest in promoting prescription drugs directly to consumers.